HUMAN RIGHTS FOUNDATION
HUMAN RIGHTS FOUNDATION OF NEW ZEALAND
TŪĀPAPA TIKA TANGATA O AOTEAROA

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22 March 2019

Hon David Parker
Attorney-General
Parliament Buildings
Wellington 6160
New Zealand

**BY EMAIL:** d.parker@ministers.govt.nz

**Re: Inquiry following Christchurch Mosque attacks**
**Terms of Reference**

Dear Sir,

We write regarding the Prime Minister's announcement dated 18 March 2019 about an inquiry into the background to the Christchurch Mosque attacks, including the roles played by various Government agencies including the New Zealand Security Intelligence Service (NZSIS). We understand Terms of Reference are being finalised for this proposed inquiry and we wish to express our views as members of civil society regarding the need for transparency and openness in the Inquiry.

Our organisation and members of our Executive Management team have had extensive experience in legal matters and hearings involving both classified and confidential information for the past twenty years. We have long-standing links with the New Zealand Muslim community. These links reach back to the *Ahmed Zaoui* case and more recently in a Rule of Law project we have worked on between the Muslim community and New Zealand government agencies from 2016 to the current date.

We have been persistently raising concerns with relevant government agencies about increasing concerns of Islamophobia internationally and in New Zealand and raising concerns about intrusion into the civil liberties and rights of the Muslim community, including over-surveillance and monitoring. We have been extensively seeking dialogue and change from government agencies including the New Zealand Security and Intelligence Services and the New Zealand Customs Service.

Members of our Executive Management Committee have been contacted throughout this week by members and leaders of the Muslim community about the proposed Inquiry into the Christchurch attacks, including from those with family and friends directly affected. All have expressed the need for the proposed inquiry to be open and expressed fears and concerns of it being a secret and closed process to victims, their families and the public.

The Human Rights Foundation considers that for an inquiry into "*what all relevant agencies knew or could or should have known ... and whether they could have been in a position to prevent the attack*" to be effective, it must be conducted independently and at arms-length

from the Government, and particularly from the agencies concerned. It is also essential that the inquiry be conducted with the maximum degree of transparency possible, so that the public may understand both what was done wrong, and what was done right.

We draw to your attention to the fact that overseas inquiries of a similar nature have been able to balance security concerns and the public interest in a manner which has not required confidential or secret proceedings or hearings. In the United Kingdom, for example, the Coroner's Inquest into the London Bombings of 7 July 2005 was conducted by Lady Justice Hallett in public. We **enclose** for your reference Lady Justice Hallett's concluding remarks, where she noted that with the cooperation of counsel for the families and the relevant agencies to provide material and prepare unclassified summaries, the Coroner was able to ensure that all relevant information was provided for public scrutiny. The United Kingdom Coroner's Inquest was able to provide independent oversight and give all interested parties, including affected family members, an opportunity to actively participate and hear the information.

The formulation of the Terms of Reference for any inquiry into the Christchurch attacks is critical. The Human Rights Foundation strongly urges you to make plain in the Terms of Reference that the starting point for the Inquiry into the Christchurch attacks must be openness, not secrecy. Establishing such a starting point clear is essential to ensure this inquiry is as open and transparent as possible. To fail to be explicit on the need for a presumption of openness risks an overly closed and secret inquiry, which would be detrimental to the interests of justice and in particular to the victims and their families.

This is New Zealand's first experience of an inquiry into a terrorist attack, and we should look to our neighbours to build and learn from their own experiences of such tragedies. At the core of this inquiry are the victims and their families, who deserve clarity about what happened.

If established with adequate terms of reference, this inquiry has the potential to be a significant and positive step for justice and accountability in New Zealand. It is of paramount importance that the victims and families of the Christchurch Mosque attacks be permitted to have a meaningful role in the inquiry and that the starting point of the inquiry is therefore openness not secrecy.

Please feel free to contact the Foundation if you have any questions, wish to discuss further, or for any other reason.

Yours faithfully,

**Peter Hosking**
**Chairperson**


# Coroner's Inquests into the London Bombings of 7 July 2005

## Hearing transcripts

### 6 May 2011

1 Friday, 6 May 2011
2 (10.00 am)
3 Concluding remarks
4 LADY JUSTICE HALLETT: I should like to begin by thanking
5 those involved in these proceedings. The list is a long
6 one.
7 First, I should like to thank the bereaved families
8 who lost their loved ones on 7 July 2005 for their
9 understanding, for their support and their quiet
10 dignity. They have waited for nearly six years for
11 these proceedings to reach this stage. Despite their
12 obvious grief, they have maintained their sense of
13 fairness and moderation. They want to find out what
14 happened, how their loved ones died, and whether the 52
15 deaths could have been prevented, but they do not
16 necessarily seek to cast blame.
17 When we began this process, there were reservations
18 in a number of quarters about the need to resume the
19 inquests into the deaths of the 52 people murdered in
20 London on 7 July 2005. However, these proceedings have
21 gone much further than simply recording the sad fact
22 that 52 innocent members of the travelling public were
23 unlawfully killed in a dreadful act of terrorism. We
24 have explored in detail the circumstances of the deaths
25 of each of the 52 individuals and the adequacy of the

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1 emergency response. We have examined the background of
2 Mohammed Sidique Khan, Shehzad Tanweer, Hasib Hussain
3 and Jermaine Lindsay, the extent to which any of them
4 had previously come to the attention of the authorities
5 and how they were assessed by the Security Service. We
6 have unearthed material which has never previously seen
7 the light of day. We have caused organisations to
8 reassess their own systems and to acknowledge that,
9 despite improvements already made, more may be possible.
10 As a result, I have been able to reach certain
11 conclusions on the performance before 7/7 and on 7/7 of
12 the various organisations represented before me. I feel
13 able to make recommendations which the families hope
14 will result in improvements to the benefit of the public
15 generally, improvements which may save lives.
16 The bereaved families have had most of their
17 questions answered. Mr Neil Saunders, on behalf of the
18 represented bereaved families, was kind enough to
19 acknowledge that they feel the inquests have been as
20 thorough as they could legitimately have expected. Even
21 if a particular family member disagrees with any of my
22 conclusions, they have each had the opportunity to see
23 the material for themselves and to have the evidence
24 tested, wherever they lived. The material which formed
25 the basis of the questioning and a transcript of the

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1 days' proceedings was published on the website each day.
2 Families across the world affected by the London
3 bombings were, at the very least, entitled to that. The
4 same goes for the survivors, who are the next group of
5 people I wish to thank.
6 During the course of hearing evidence I ran out of
7 superlatives in describing the courage and heroism of
8 many of the surviving passengers on the Tubes and the
9 bus, and others who went to assist: from the desperately
10 injured who fought with death, to the passengers on the
11 bombed trains or passing trains, who, giving no thought
12 to their own safety, went to the aid of the dead and
13 injured. Members of the public played a huge part in
14 the rescue mission. Whilst I have had the opportunity
15 to express my gratitude to those from whom I have heard
16 evidence, I would also like to express my thanks to all
17 those from whom I have not heard for all their efforts
18 on that day.
19 There was a time when some of those who survived
20 wanted a public inquiry into what happened. These are
21 inquests governed by coronial law and, as such, they are
22 very different by their nature from a public inquiry.
23 However, throughout these proceedings, I made it plain
24 that I was happy to receive suggestions for possible
25 lines of enquiry from the survivors and from members of

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1 the public generally. I have considered carefully every
2 message received. I hope and believe the survivors have
3 not felt left out of the process.
4 I am not aware of our having left any reasonable
5 stone unturned. One would hope, therefore, that these
6 proceedings will be an end to the investigation of what
7 happened on 7/7. Many of the witnesses dreaded giving
8 evidence before me. A large number are still suffering
9 from post-traumatic stress and reliving the events of
10 7/7 was the last thing they needed. I wish to thank all
11 those who were prepared to put their own suffering to
12 one side to help me and the bereaved families.
13 In that category, I include those who went to the
14 scene as part of the rescue missions. These included
15 members of the public, doctors and staff from the
16 British Medical Association, members of
17 London Underground staff, officers from the British
18 Transport Police, the Metropolitan Police Service and
19 the City of London Police, members of the London Fire
20 Brigade, the London Ambulance Service and volunteers
21 from London's Air Ambulance, otherwise known as HEMS.
22 I have seen the unedited photographs of each scene, yet
23 I still cannot imagine the full extent of the horror
24 that greeted them on that day.
25 For those tasked with investigating the scene, the

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1 horror continued for many long, physically draining
2 days. I would like to thank the original investigators,
3 those who assisted me in my investigation and the
4 experts and the scientists who went out of their way to
5 provide the best possible analysis of the forensic
6 evidence. I am also indebted to the Ministry of Defence

7 who decided to devote considerable and hard pressed
8 resources to helping us. If the work of the experts
9 under Colonel Mahoney's "command" for us may in the
10 future contribute to the saving of lives in the
11 military, the families will feel something especially
12 positive has come out of this process.
13 I should mention again the Metropolitan Police
14 Service because it occupies a unique position in that it
15 performs a number of overlapping functions. Not only
16 were its officers among the first responders, the
17 Metropolitan Police was responsible for the
18 investigation into the bombings, known as
19 Operation Theseus, as a result of which it holds more
20 than 30,000 statements and 40,000 exhibits on its HOLMES
21 database. We have drawn considerably upon that
22 material, supplementing it where necessary. The
23 Metropolitan Police also acts as my Coroner's Officers
24 (in what they have called "Operation Ramus"). The
25 Operation Ramus team consisted of over 30

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1 Metropolitan Police officers and staff.
2 I am greatly indebted to that team and Chief
3 Superintendent McKenna in particular for their
4 dedication and industry in assisting in the collation
5 and preparation of this material for the inquests. They
6 have been inundated by our requests for further
7 information and documents, to which they have responded
8 with commendable efficiency.
9 Similarly, I have made huge demands upon the other
10 police forces involved and also upon the
11 Security Service. I am acutely conscious that I have
12 taken men and women who perform the vital function of
13 protecting the public from their normal duties. I truly
14 hope that the impact upon their respective services has
15 not been too great and that there is now a general
16 acceptance of the importance of the process to the
17 bereaved and to the families and to the public.
18 To my mind, the concerns that I would not be able to
19 conduct a thorough and fair investigation into the
20 security issues in wholly open evidential proceedings
21 have proved unfounded.
22 Although it was necessary to hold some closed
23 procedural hearings, during which intense time and
24 effort was devoted by my team (in particular
25 Mr Andrew O'Connor) the Security Service and the police

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1 to ensuring that as much relevant information as
2 possible was put into the public domain, I am happy to
3 report that they were very few. I should emphasise that
4 these hearings were procedural only. I did not hear or
5 consider evidence as such in the course of them.
6 Instead, the Security Service and the police put before
7 me material that was relevant to the issues, but which
8 they reasonably believed could not be disclosed in an
9 unredacted form without threatening national security.
10 The system did in fact work well. I can confirm
11 that a careful process was undertaken to ensure that
12 open summaries of the relevant content of this material
13 were prepared that were as full as possible, consistent
14 with the interests of national security. This process
15 was completed to my satisfaction. The resulting public

16 gists were detailed and, together with the disclosed
17 documentation and the lengthy oral evidence, this
18 material allowed the most intense public scrutiny of the
19 relevant issues.
20 I know that the extremely tight timetable I set was
21 meant that an enormous number of people from the various
22 organisations represented before me, such as witnesses,
23 support staff and inhouse lawyers have dedicated
24 significant time and resources to assisting this
25 process. I was promised the fullest cooperation by

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1 everyone and that is what I have received.
2 I doubt that many lawyers will have been involved in
3 such a consistently harrowing and difficult case. The
4 legal teams before me instructed by the families and the
5 organisations have read and considered huge quantities
6 of documentation. Much of this was produced for us by
7 the police and the Security Service, but also
8 a considerable quantity was generated specifically for
9 these proceedings. It was then disclosed by me
10 following a lengthy exercise of collation and analysis
11 by my legal team. Many of the lawyers have given up
12 holidays and precious family time. I am very grateful
13 to them for their industry, their representation, and
14 for their care in ensuring that their questioning and
15 submissions focused on the central and essential issues.
16 Over 300 witnesses have been called; the statements
17 of about 200 witnesses have been read. We have managed
18 to adhere to our timetable, to the very day and very
19 hour set. We have conducted the most thorough and
20 complex review into the deaths of 52 people and we have
21 completed the process significantly under budget without
22 anyone claiming they have not had a proper opportunity
23 to be heard. This is a huge tribute to the skills and
24 industry of the inestimable Inquest team and I am
25 extremely grateful to them. I mention just six, the six

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1 upon whom the greatest burdens fell for the greatest
2 length of time: Hugo Keith QC, Andrew O'Connor,
3 Benjamin Hay, Martin Smith, Tim Suter and Judy Anckorn.
4 At the beginning of the process, I decided upon
5 a lengthy list of relevant issues to be explored during
6 the inquests, contained in a document headed
7 "Provisional Index of Factual Issues". Many of them no
8 longer remain an issue because they have fallen away as
9 the evidence has been heard. It should not be thought
10 that because I make no mention of an issue, it was
11 unimportant. It simply means that, having conducted
12 a full, fair and effective enquiry, questions have been
13 answered in such a way that the issue need play no part
14 in my verdicts or in my rule 43 report.
15 It is important to record what my powers are before
16 I deliver my verdicts. It would not be appropriate for
17 me to write a full judgment or report of the kind
18 I would produce if sitting as a judge in the Court of
19 Appeal or chairing a public inquiry. I am limited to
20 recording verdicts and submitting a rule 43 report where
21 I consider it appropriate. If, therefore, anyone is
22 expecting a summary of all the evidence, the issues and
23 my conclusions upon them, they are mistaken. However,
24 as I have made clear, I believe that although the format

25 may not be the same as a judgment or a report, the

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1 cumulative effect of the hearings themselves, the
2 verdicts and the rule 43 reports will be in essence what
3 the bereaved and the survivors would have required of
4 a public inquiry.
5 Section 11(5) of the Coroners Act 1988 requires
6 that:
7 "An inquisition - shall be in writing under the hand
8 of the coroner ... shall set out, so far as such
9 particulars have been proved - who the deceased was; and
10 how, when and where the deceased came by his death."
11 Rule 36 of the Coroners Rules 1984 echoes that
12 provision in describing the functions of an inquest.
13 However, it adds, rule 36(2):
14 "Neither the coroner, nor the jury, shall express
15 any opinion on any other matters."
16 Rule 42 provides:
17 "No verdict shall be framed in such a way as to
18 appear to determine any question of:
19 "(a) criminal liability on the part of a named
20 person; or
21 "(b) civil liability."
22 Last year, I ruled that these would be "Jamieson"
23 type inquests following the judgment of
24 Sir Thomas Bingham, Master of the Rolls, in R v North
25 Humberside Coroner, ex parte Jamieson [1995] QB 1.

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1 However, as Mr James Eadie QC observed during closing
2 submissions, there were times when the casual observer
3 would have been hard pressed to tell the difference
4 between these inquests and a wider ranging article 2
5 "Middleton" type inquest following (R (Middleton) v West
6 Somerset Coroner [2004] 2 Appeal Cases, 182). My
7 decision, however, does impact upon the content of the
8 verdicts.
9 It now appears to be common ground that there are
10 very real constraints upon me in completing the
11 inquisitions. These were explained by
12 Sir Thomas Bingham in Jamieson. He used the words
13 "a brief, neutral, factual statement" to describe the
14 permissible content of a verdict which does not offend
15 the Coroners Rules 1984 in non-article 2 inquests. He
16 gave three examples.
17 "The deceased was drowned when his sailing dinghy
18 capsized in heavy seas."
19 "The deceased was killed when his car was run down
20 by an express train on a level crossing."
21 "The deceased died from crush injuries sustained
22 when the gates were opened at Hillsborough Stadium."
23 Plainly he meant brief, neutral and factual and not,
24 as Mr Patrick O'Connor QC appeared at one time to argue,
25 lengthy and contentious. Such a verdict would plainly

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1 offend rules 36, 42 and the principles governing
2 non-article 2 inquests, unless, of course, the evidence
3 permitted a proper conclusion that failings of some
4 description played a causative part in the death.
5 However, it is also now common ground that the

6 evidence I have heard does not justify the conclusion
7 that any failings on the part of any organisation or
8 individual caused or contributed to any of the deaths.
9 In this regard, I will turn in a moment to address the
10 issue of survivability. All agree that concerns about
11 what happened before 7/7 or on the day cannot properly
12 and lawfully be reflected in the verdicts. That does
13 not mean, of course, that legitimate concerns which give
14 rise to possible risk to life in the future cannot be
15 reflected in a rule 43 report, to which I shall also
16 return.
17 With the considerable assistance of my legal team,
18 I have prepared, and I alone have reached verdicts of
19 unlawful killing on the 52 innocent people killed by the
20 four bombs. I shall now ask Mr Hugo Keith QC to read
21 out each of the names of the deceased.
22 MR KEITH: James Adams, Samantha Badham, Lee Baisden,
23 Philip Beer, Anna Brandt, Michael Brewster,
24 Ciaran Cassidy, Rachelle Chung For Yuen,
25 Benedetta Ciaccia, Elizabeth Daplyn, Jonathan Downey,

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1 Richard Ellery, Anthony Fatayi-Williams, David Foulkes,
2 Arthur Frederick, Karolina Gluck, Jamie Gordon,
3 Richard Gray, Gamze Gunoral, Lee Harris, Giles Hart,
4 Marie Hartley, Miriam Hyman, Ojara Ikeagwu,
5 Shahara Islam, Neetu Jain, Emily Jenkins,
6 Adrian Johnson, Helen Jones, Susan Levy, Sam Ly,
7 Shelley Mather, Michael Matsushita, James Mayes,
8 Anne Moffat, Colin Morley, Behnaz Mozakka,
9 Jennifer Nicholson, Mihaela Otto, Shyanu Parathasangary,
10 Anat Rosenberg, Philip Russell, Atique Sharifi,
11 Ihab Slimane, Christian Small, Fiona Stevenson,
12 Monika Suchocka, Carrie Taylor, Mala Trivedi,
13 Laura Webb, William Wise, Gladys Wundowa.
14 LADY JUSTICE HALLETT: Thank you. I have attached the
15 inquisition forms to this ruling and I hand them down
16 today. I do not intend to distress the families
17 unnecessarily by reading out each one individually.
18 Some, I know, will find I have been forced to include
19 detail that they had hoped could be avoided. Some will
20 find I have not included as much detail as they would
21 have wished. I hope they understand that much as my
22 Inquest team and I have borne the wishes of the families
23 in mind at every stage of the proceedings, when it comes
24 to formal matters such as the recording of the verdicts,
25 I am subject to the constraints imposed by the rules on

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1 a Jamieson verdict and I am obliged to provide some
2 degree of neutral specificity as to the circumstances of
3 death.
4 Rule 43. Rule 43(1) of the Coroners Rules 1984 as
5 amended by the Coroners (Amendment) Rules 2008 provides
6 as follows:
7 "Where:
8 "(a) a coroner is holding an inquest into a person's
9 death;
10 "(b) the evidence gives rise to a concern that
11 circumstances creating a risk of other deaths will occur
12 or will continue to exist in the future; and
13 "(c) in the coroner's opinion, action should be
14 taken to prevent the occurrence or continuation of such

15 circumstances, or to eliminate or reduce the risk of
16 death created by such circumstances.
17 "The coroner may report the circumstances to
18 a person who the coroner believes may have power to take
19 such action."
20 I heard submissions, both as to the scope of my
21 power under rule 43, and as to the approach that
22 I should adopt as to the exercise of that power in the
23 particular circumstances of these inquests. In the
24 light of those submissions, I make the following
25 preliminary observations, which are largely, if not

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1 entirely, the subject of consensus between the
2 interested persons.
3 The effect of the amendment to rule 43 in 2008 was
4 significantly to enlarge its scope. Whereas previously
5 the power could only be exercised with a view to
6 preventing similar deaths to those under investigation
7 at the inquest, a report can now be made relating to any
8 risk of further deaths, whether or not similar to the
9 deaths under investigation.
10 One consequence of this broadening of the scope of
11 the rule 43 power is that there is now a significant
12 distinction between the circumstances in which a coroner
13 is required to summon a jury under section 8(3)(d) of
14 the Coroners Act 1988 (which remain narrowly focused on
15 concerns relating to future similar deaths) and
16 circumstances justifying a report under rule 43. For
17 the record, whilst I have concluded, as set out below,
18 that there are a number of matters that justify the
19 making of a report under rule 43, I do not consider that
20 the conclusions I have reached on these matters are such
21 as to engage the mandatory requirement in
22 section 8(3)(d) to summon a jury.
23 I was addressed in some detail on the wording of
24 rule 43 and the criteria for exercising the power to
25 make a report. There are four features worthy of note.

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1 First, the condition for the exercise of the power
2 is that the coroner has a concern as to circumstances
3 creating a risk to life. This is a relatively low
4 threshold. The rule does not require, for example, that
5 I have concluded or am satisfied that such circumstances
6 exist. Second, the substance of the concern must be
7 circumstances creating a risk to life, but those
8 circumstances need not already exist at the time of the
9 decision to make a report. The concern must be of
10 a risk to life caused by present or future
11 circumstances. Third, the concern must be based on
12 evidence. Fourth, the coroner must be of the opinion
13 that action should be taken to respond to the concern as
14 to risk to life. However, it is neither necessary, for
15 appropriate, for a coroner making a report under rule 43
16 to identify the necessary remedial action. As is
17 apparent from the final words of rule 43(1), the
18 coroner's function is to identify points of concern, not
19 to prescribe solutions.
20 The focus of the evidence that I have heard during
21 this inquest has, of course, been on the events of
22 7 July 2005. A great deal of evidence has been given
23 about the systems in place and the equipment used by

24 Transport for London and the emergency services on that
25 day. With regard to the "preventability" issues, I have

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1 also heard evidence as to police and Security Service
2 capabilities and techniques in the years 2004 and 2005,
3 although the open nature of these proceedings has meant
4 that evidence could not be adduced regarding some
5 sensitive details. In addition, I have heard evidence
6 regarding changes and improvements that have taken
7 place, with the same proviso in relation to the
8 Security Service since that time.
9 In some instances, any concerns regarding systems
10 that were in place in 2005, and which would have
11 justified the making of a report, have been dispelled by
12 the evidence of improvements that have been made since.
13 There are other areas in which such evidence as I have
14 heard about developments since 2005 have not been
15 sufficient to allay my concerns: they are the subject of
16 my report.
17 The interested persons were in agreement that, in
18 order to explain the recommendations that I am making,
19 and to put them into context, it would be helpful for me
20 to summarise some of my factual findings on relevant
21 areas of the evidence. I agree that, in the
22 circumstances of these inquests, this is an appropriate
23 course to adopt, and I have done so. I have also made
24 reference to some (but not all) of the recommendations
25 that I was invited to make in submissions but which

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1 I have decided not to pursue, and I have briefly given
2 my reasons for doing so. Again, the interested persons
3 were in agreement that I was entitled to do that.
4 I should also add that, given the exceptional nature of
5 the inquests, my rule 43 report is bound to be far more
6 detailed than would usually be the case.
7 I should now mention the question of "survivability"
8 which relates directly to my verdicts. When we began
9 the inquests, a number of the families questioned
10 whether or not their loved one might have survived if
11 help had reached them sooner. I am also acutely
12 conscious of how important it can be to some bereaved
13 families to know the exact circumstances of the death of
14 their loved ones. I have therefore reviewed the
15 evidence on this issue with the greatest of care, not
16 just in relation to Carrie Taylor and Shelley Mather
17 (whose families specifically maintained their requests
18 that I do so), but in relation to all the deceased. For
19 some, their injuries were so severe they would have died
20 instantly. For others, the position was less clear-cut.
21 Some survived for minutes, hours, even days after the
22 explosion before, sadly and finally, succumbing to their
23 injuries.
24 I was considerably assisted in my task by the work
25 of Colonel Mahoney and his team of experts. They were

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1 asked to explain the mechanics of death for someone
2 injured in an explosion generally and to consider the
3 cases of a number of the deceased who did not make it to
4 hospital where either the evidence indicated at first

blush they might not have died immediately or because I had accepted a request from legal representatives to look at the issue for a particular deceased. We required Colonel Mahoney's assistance because the decision was taken not to hold internal post-mortem examinations of the 52 victims. Some of the families approved of that decision and some did not. Those in the latter group invited me to recommend that "coroners should receive guidance" on the holding of internal post-mortems even where the effective cause of death is known, "if it is thought issues of survivability might arise". They also asked me to consider recommending, in effect, that bereaved families be given a greater say in the decision-making process. I understand that this is an issue that has troubled and continues to trouble some. However, I ruled that this issue is outside the scope of the inquests and I have heard no evidence at all on how decisions of this kind are taken and what the reasons for this particular and very difficult decision were. I should say, for the avoidance of doubt, that having heard nothing on the subject, I have no reason to

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doubt that the reasons were entirely sensible and the decision justified, but ultimately the issue is not a question for me.
I return to the evidence of Colonel Mahoney and his team. Colonel Peter Mahoney is the Defence Professor of anaesthetics at the Royal Centre for Defence Medicine. He and his team have extensive experience of treating military personnel injured by bombs and/or of reviewing the deaths of those killed in explosions. They are skilled at addressing the question of whether someone injured in an explosion who suffers a particular combination of injuries will be expected to survive. Colonel Mahoney's evidence was that an explosion is a rapid release of energy that sends out a high pressure shock wave followed by a blast wind which is the heat and explosive material radiating rapidly outwards. The combined effect is called the blast wave. Those who are unfortunate enough to be caught up in and injured by an explosion suffer what the Colonel categorised as blast injuries. Obviously the closer the victim is to the seat of the explosion, the greater the risk of death, and the further away, the greater the chances of survival. Very small distances can make all the difference to the chances of survival.
He divided blast injuries into different categories;

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the most significant being primary blast injuries which usually involve serious trauma to internal organs containing air such as the lungs and bowel. There may be no or limited signs of external injury in those who have predominantly suffered primary blast injuries.
I also heard that in an enclosed space, such as an underground carriage or a bus, the incidence of primary blast injuries is likely to be greater than in an open environment. This is due to the concentration of the shock wave. The blast wave, as it spreads out in an enclosed space, can reflect off surfaces so that the effects of the blast are concentrated in particular areas.

14 A particular and, sadly, common example of primary
15 blast injury is blast lung. I heard evidence that the
16 lungs are particularly vulnerable to such injury. Blast
17 lung is categorised as bleeding into lung tissue. Blood
18 flowing through injured areas of the lung does not
19 contain sufficient oxygen; essentially the lungs become
20 stiffer and breathing more difficult. Blast lung can
21 evolve and worsen over the hours and days after an
22 explosion. It is a progressive illness and respiratory
23 function can deteriorate very rapidly. Although
24 Colonel Mahoney took care to emphasise that there were
25 always variables and exceptions, scientific research

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1 showed that a significant proportion of those who
2 suffered such injuries, but did not die immediately,
3 would subsequently succumb due to blast lung.
4 Bearing this evidence in mind, I have considered
5 whether any of the deceased could, on the balance of
6 probabilities, have survived the injuries they suffered
7 in case that had any impact on my verdicts in their
8 inquests. I do not intend to dwell upon the detail
9 because, in relation to the vast majority of the
10 victims, I am not now asked to do so. I have concluded,
11 bearing in mind Colonel Mahoney's caveats and the
12 severity of the injuries suffered by some of those who
13 survived, that the medical and scientific evidence in
14 relation to all 52 victims leads to only one sad
15 conclusion: I am satisfied on the balance of
16 probabilities that each of them would have died whatever
17 time the emergency services had reached and rescued
18 them. Consequently, there is nothing for me to add in
19 relation to this issue in box 3 of any of the
20 inquisition forms.
21 Turning to Carrie Taylor in a little more detail, as
22 I am asked to do, she survived, on the evidence, for
23 approximately 30 minutes or so after the explosion. She
24 was thought to speak to some of the witnesses. However,
25 one witness described her as unresponsive and

22

1 Dr Quaghebeur, a fellow passenger who was on the scene
2 throughout, described her as making involuntary
3 movements and being uncommunicative.
4 Colonel Mahoney's carefully reasoned conclusion was
5 that the nature of her injuries, in particular the flash
6 burns and partial traumatic amputation of her leg,
7 indicated that Carrie was close to the source of the
8 explosion at Aldgate; closer than the initial assessment
9 which put her about 2.6 metres away. I fully understand
10 that Mr Taylor does not accept the analysis that she was
11 closer, particularly as Carrie was shielded from the
12 blast by at least three other passengers. However,
13 I can find no evidence to contradict the expert
14 assessment that the nature of her injuries indicates
15 a close proximity to the blast. I accordingly accept
16 that it was likely that she was exposed to several shock
17 waves, each with the potential of causing some degree of
18 primary blast injury. I am persuaded by
19 Colonel Mahoney's evidence that it was very likely that
20 Carrie suffered significant blast lung injury and that
21 she was thrown by the force of the blast from her
22 initial position with the likelihood of significant

23 other injuries including head and spinal injury. On the
24 balance of probabilities, in my judgment, it was
25 unlikely that Carrie Taylor would have survived.

23

1 Consequently, there is nothing for me to add in relation
2 to this issue in box 3 of the inquisition form for
3 Carrie.
4 Thus, the only legitimate comfort I can give Mr and
5 Mrs Taylor is to agree with them that absent an internal
6 post-mortem, no one can now be absolutely certain that
7 Carrie would not have survived. Colonel Mahoney said
8 there are no certainties in this area. However, as
9 I have said, on the balance of probabilities, the expert
10 evidence points to only one conclusion: it is unlikely
11 she would have survived, whatever time she was
12 extricated from the carriage.
13 In relation to Shelley Mather, Colonel Mahoney
14 concluded that, given the nature of the fragmentary
15 injuries that she suffered, it was likely that the
16 device on the Russell Square train exploded close, but
17 not next to her. Her injuries indicated that the device
18 exploded to her left. She probably survived for
19 approximately 1 hour and 40 minutes after the explosion.
20 I heard evidence from Susan Harrison, who was badly
21 injured in the blast, that she was blown on to Shelley.
22 After the explosion, they were holding hands and
23 speaking to each other. When paramedics arrived at the
24 scene, Shelley was still conscious and presented as
25 gasping for breath with a distended abdomen. A number

24

1 of unsuccessful attempts were made to decompress her
2 chest; a build-up of air from an air leak inside the
3 chest, known as a pneumothorax, was suspected as a cause
4 of the breathing difficulties. There is nothing to
5 suggest that those efforts at chest compression would
6 not have successfully drained a pneumothorax, if one
7 existed.
8 Shelley's breathing difficulties continued after the
9 decompression. Colonel Mahoney concluded, therefore,
10 that the most likely explanation was that Shelley had
11 a severe blast lung injury. She had been close to, but
12 not next to the bomb, when it was detonated. Her
13 distended abdomen also indicated the possibility of
14 other internal injury or that Shelley was swallowing
15 a lot of air. This could also indicate blast lung.
16 Taking the evidence as a whole, noting in particular the
17 valiant efforts made by the medics at the scene,
18 I conclude that on the balance of probabilities it was
19 unlikely that Shelley would have survived her injuries
20 even if she had been extricated from the scene earlier.
21 In a moment, I will ask Mr Smith to hand out the
22 inquest forms to the legal teams and any unrepresented
23 bereaved families who are present. Before I do, it is
24 my intention to publish the inquisition forms on the
25 inquest website as the formal record of each of the

25

1 52 inquests; does anyone wish to make submissions on
2 that before I do so?
3 I announced on 11 March 2011 that I intended to make

4 a report under rule 43. I intend to publish it now, and
5 I have obtained the agreement of the Lord Chancellor (to
6 whom I am indebted), with whom a power lies to publish
7 such a report. It will be available, therefore, about
8 now on the inquests website for anyone who wishes to see
9 it. Mr Smith will be sending out the rule 43 report to
10 those to whom it is addressed later today and he will be
11 copying it formally to all interested persons.
12 Unless anyone has anything else to add, I therefore
13 propose formally to close the inquests into the
14 52 deceased.
15 There is one other matter to which I must now turn.
16 I also have jurisdiction over the inquests into the
17 deaths of Mohammed Sidique Khan, Shehzad Tanweer,
18 Hasib Hussain and Jermaine Lindsay and thus the
19 responsibility of deciding whether or not I should, in
20 my discretion, resume any or all of those inquests.
21 Under section 16(3) of the Coroners Act 1988, an inquest
22 may be resumed only if, in the opinion of the coroner,
23 they have sufficient cause to do so.
24 In my ruling in May of last year, I adjourned
25 consideration of this issue to give time to the families

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1 of these men to advance submissions if they wished to do
2 so. However, nothing was put before me at that time
3 that would have justified resumption of any of their
4 inquests and I made it clear that I would require good
5 and proper reasons before doing so.
6 On 11 March 2011 I ordered that any person wishing
7 to make representations should do so by 18 March. In
8 the event, none of the families have sought to argue
9 that any of these inquests should be resumed or, indeed,
10 submitted any representations at all. The only
11 submissions I have received have come from an
12 organisation calling itself the July 7th Truth Campaign.
13 I have considered those submissions, but in the light of
14 all the evidence I have heard during the 52 inquests,
15 I consider they have not provided any sufficient reason
16 to resume the inquests into the four bombers. In any
17 event, I consider that the organisation does not fall
18 within the legal criteria for an interested person
19 contained in rule 20(2) of the Coroners Rules 1984.
20 In the light of the position adopted by their
21 families, and given that the inquests into the deaths of
22 the 52 victims have led to the most rigorous scrutiny of
23 the events of 7 July 2005, I can find no cause
24 whatsoever to resume the inquests into the deaths of the
25 four men.

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1 Thank you all for your assistance.
2 MR KEITH: My Lady, before you rise, may I record, on behalf
3 of all those of us who have engaged in these
4 proceedings, our gratitude and appreciation of your
5 dedication, your conscientiousness and your humanity in
6 your conduct of these proceedings?
7 LADY JUSTICE HALLETT: Thank you, Mr Keith.
8 (10.47 am)
9 (The inquests adjourned)
10
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